Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOWNTOWN PERFORMANCE MEDICAL CENTER
DBA IMAGE MEDICAL CLINIC
3033 FANNIN STREET
HOUSTON TX 77004

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
JACOBS ENGINEERING GROUP INC

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-10-4969-01

MFDR Date Received
August 3, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The payment was denied with the following reason: · based on entitlement to benefits. On 5/11/2010, The Benefit Dispute Agreement states 'the claimant sustained a compensable injury on 11/16/09….the parties agree compensable injury does extend to include the medial meniscus tears in the left knee…..the Claimant does have a disability from 11/23/09 through present.' "

Amount in Dispute: $3,657.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent was notified on August 9, 2010. No response was received.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 23, 2009	99204 99080-73	$216.00 $ 15.00	$214.03 $ 15.00
November 23, 2009	G0283-GP 97124-GP	$ 18.00 $ 34.76	$ 17.41 $ 33.58
November 24, 25, 2009	G0283-GP x 2 days 97035-GP x 2 days 97124-GP x 2 days	$ 36.00 $ 36.10 $ 69.52	$ 34.82 $ 34.94 $ 67.16
December 7, 9, 18, 21, 23, 29, 30, 2009	97110-GP x 4 units x 7 days 97140 x 7 days	$1200.78 $ 281.33	$1186.85 $ 272.93
December 16, 2009	97110-GP x 4 units	$171.54	$ 0.00
January 4, 6, 7, 11, 25, 28, 29, 2010	97110-GP x 4 units x 7 days	$1200.78	$1200.78
January 13, 2010	99213 99080-73	$ 84.32 $ 15.00	$ 84.32 $ 0.00
January 4, 6, 7, 11, 25, 28, 2010	97140-GP x 6 days	$241.14	$241.14

January 29, 2010	98940-GP	$ 36.80	$ 36.80
	TOTAL DUE		$3,439.76

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 relates to MDR – General.
3. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional services on or after March 1, 2008.
7. 28 Texas Administrative Code §129.5 sets out the guidelines and reimbursement for work status reports.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 218 - Based on entitlements to benefits.
   - 880-126 – Denied per insurance: coverage of the injury disputed.
   - 80-197 - Denial code E: entitlement to benefits.
   - 45 – A description was not provided on the explanation of benefits; however, the ANSI description ''Charges exceed your contracted/legislated fee arrangement.
   - 29 – The time limit for filing has expired.
   - 855-066 – Based on fee schedule guidelines, bills submitted after the 95th day after the date of service are disallowed.

Issues

1. Is the disputed service eligible for medical fee dispute resolution per 28 Texas Administrative Code §133.305 and §133.307? Did the requestor treat the compensable knee and lumbar sprain/strain?
2. Did the requestor submit the medical bill for date of service December 16, 2009 timely and in accordance with 28 Texas Administrative Code §133.20? Did the requestor submit documentation to support that this disputed bill was submitted timely in accordance with Texas Labor Code Section §408.027?
3. Did the respondent support its '45' denial reason code?
4. Is the requestor entitled to reimbursement according to 28 Texas Administrative Code §§134.203 and 129.5?

Findings

1. A Benefit Dispute Agreement (DWC-24) was signed on May 11, 2010 to resolve that the claimant sustained a compensable injury on November 16, 2009 and that the compensable injury does extend to include the medial meniscus tears in the left knee. Therefore, the compensability and extent of injury issues have resolved and the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.

   The medical bills submitted by the requestor in this dispute were reviewed. The requestor billed diagnosis codes 844.9-SPRAIN and STRAIN OF UNSPECIFIED SITE OF KNEE&LEG and 847.2-LUMBAR SPRAIN and STRAIN. The medical documentation submitted by the requestor in this dispute was reviewed. The Division concludes that the documentation sufficiently supports that the treatment rendered was for the compensable knee and lumbar strain/sprain.
2. The respondent denied reimbursement for date of service December 16, 2009 based on '29 – The time limit for filing has expired' and '855-066 – Based on fee schedule guidelines, bills submitted after the 95th day after the date of service are disallowed'.

Pursuant to 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that Texas Labor Code §408.0272 applies to the service in dispute. For that reason, the requestor in this dispute was required to send the medical bill no later than 95 days after the service in dispute was provided.

Review of the documentation submitted by the requestor finds a document dated January 20, 2010 titled 'INITIAL SUBMISSION' which states in part, 'Bills and records pertaining to the above-mentioned patient for services rendered on 12/16/09 are in [sic] included in this fax.' This bill was submitted untimely. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the December 16, 2009 disputed date of service.

3. According to the submitted explanations of benefits dated March 29, 2010 and April 9, 14, 26, 2010, the carrier denied payment for the services in dispute in accordance with a contract. The "Network Reduction" amount on the submitted explanations of benefits dated March 29, 2010 and April 9, 14, 26, 2010 denote a "0.00" reduction. The respondent did not clarify or otherwise address the 45 claim adjustment code upon receipt of the request for dispute resolution, nor was documentation provided to support a contractual agreement. For these reasons, the division finds that the 45 claim adjustment code is not supported and the disputed services will be reviewed per applicable Division rules and fee guidelines.

4. In order to determine proper reimbursement, CCI edits were run in accordance with 28 Texas Administrative Code §134.203 (b)(1) which states: "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

No CCI edits were found. As a result, reimbursement is recommended as follows for services billed in 2009:

CPT code 99204: WC conversion factor (CF) $53.68 ÷ Medicare conversion factor (CF) $36.0666 x participating amount $143.80 = $214.03

CPT code G0283: WC CF $53.68 ÷ Medicare CF $36.0666 x participating amount $11.70 = $17.41 x 3 days = $52.23

CPT code 97124: WC CF $53.68 ÷ Medicare CF $36.0666 x participating amount $22.56 = $33.58 x 3 days = $100.74

CPT code 97035: WC CF $53.68 ÷ Medicare CF $36.0666 x participating amount $11.74 = $17.47 x 2 days = $34.94

CPT code 97140: WC CF $53.68 ÷ Medicare CF $36.0666 x participating amount $26.20 = $38.99 x 7 days = $272.93

CPT code 97110: WC CF $53.68 ÷ Medicare CF $36.0666 x participating amount $28.48 x 4 units = $169.55 x 7 days = $1186.85

CPT code 99080-73. A copy of the Work Status Report was submitted for date of service November 23, 2009 and met the requirements of 28 Texas Administrative Code §129.5. Recommend reimbursement of $15.00

Reimbursement is recommended as follows for services billed in 2010:

CPT code 99213: WC CF $54.32 ÷ Medicare CF $36.0791 x participating amount $66.31 = $99.84. Requestor seeks $84.32, this amount is recommended.

CPT code 97140: WC CF $54.32 ÷ Medicare CF $36.0791 x participating amount $27.01 = $40.67 x 6 days = $244.02. The requestor seeks $241.14, this amount is recommended.

CPT code 97110: WC CF $54.32 ÷ Medicare CF $36.0791 x participating amount $28.82 x 4 units = $173.56 x 7 days = $1214.92. The requestor seeks $1200.78, this amount is recommended.

CPT code 98940: WC CF $54.32 ÷ Medicare CF $36.0791 x participating amount $24.73 = $37.23. The requestor seeks $36.80, this amount is recommended.

CPT code 99080-73. A copy of the Work Status Report was not submitted for date of service January 13, 2010; therefore, no reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due, except as noted in paragraph #2 above. As a result, the amount ordered is $3439.76.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $3439.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July , 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.